Understanding: *Claims Appeal – Medical*

For a member of the CIGNA Health Plans (SelectCare POS, HealthGuard PPO, TotalChoice, SafetyNet*) who has a complaint regarding quality of care, benefits, claim or medical necessity denials

Claims Appeal Process

What It Is

An official process established to address complaints of CIGNA HealthCare network participants with three levels for reviewing or appealing any complaints you have regarding quality of care or benefits.

The Committee that reviews your case is an independent committee within the health plan that is responsible for resolving participants' complaints.

Who It's For

Members of the State of Vermont CIGNA Health Plans (SelectCare POS, HealthGuard PPO, TotalChoice, SafetyNet) who have specific concerns or complaints – regarding quality of care and/or administrative issues – about the CIGNA HealthCare network.

**For members with the SafetyNet Plan, this document would also apply for appeals pertaining to Mental Health and Substance Abuse claims.*

Watch Your Step . . .

- When initiating the appeals process, be sure to keep a detailed record of all conversations you have regarding your complaint, including:
  - Full names of everyone with whom you speak
  - Dates of any conversations
  - Any deadlines that may affect your case
  - Any rules or restrictions regarding the appeals procedure that you don't already have in writing.
- Always specifically ask about any deadlines that may affect the outcome of your case. Then, record the name of the person who gave you the deadline, the date of your conversation and the deadline.
- Confirm all information you receive by reading your notes back to the person giving you the information.
- Keep a file of all your correspondence and phone conversations.

4 Steps to Follow . . .

See other side

State of Vermont 3/03
Cat. #586282a

The 4 Steps to the Appeal Process: *Medical*

Voluntary Program

For a member of the CIGNA Health Plans (SelectCare POS, HealthGuard PPO, TotalChoice, SafetyNet) who has a complaint regarding quality of care, benefits, claim or medical necessity denials

1

FIRST STEP

Call Member Services using the phone number on the back of your CIGNA ID card if you have a complaint or questions regarding the following:

- In-network or out-of-network benefits covered under the CIGNA plan
- Quality of care received from participating providers
- Claim denials
- Denial of services

Response Timeframe: Your inquiry or complaint will be responded to verbally within 30 calendar days. For Quality of Care complaints, you will receive a written response.

2

FIRST LEVEL APPEAL

If you are not satisfied with the response from Member Services to your complaint about a denial determination, you can initiate a **formal appeal** by following the steps below:

- Call Member Services and advise the Rep that you want to initiate a formal appeal. You may also obtain the appeal address during this phone call and send in a written appeal
- Explain (either by phone or in writing) why you believe the denial should be reconsidered. Refer to facts that support your opinion and include any relevant medical documentation from your doctor(s)
- Include any additional documentation that you feel will clarify your position

Response Timeframe: Within 30 calendar days of your phone call or of receipt of your letter; you will receive a written response to your appeal.

3

SECOND LEVEL APPEAL

If you remain dissatisfied with the response to your appeal; you may file a **formal grievance** through CIGNA HealthCare by following the steps below:

- Send a letter to the Grievance Coordinator at CIGNA HealthCare as outlined in the response letter received in step 2.
- Restate the reasons you believe the original denial decision should be reversed
- Include all pertinent information and documentation that you feel will substantiate your position. Include any new information not already provided

When the CIGNA HealthCare Grievance Coordinator receives your formal grievance:

- An official Grievance Committee will review your case within 30 calendar days and:
- Will give you the option of presenting your case in person or telephonically to the Grievance Committee at a scheduled time. At the hearing, the committee members can ask you questions to clarify your position. You will be given at least 2 weeks advance notice of the meeting

Response Timeframe: The Committee will notify you of their decision in writing within 5 business days following the Grievance Committee meeting.

4

FINAL APPEAL

If you are not satisfied with the decision of the internal Grievance Committee you may be eligible for a third level appeal as outlined in the response letter.

NOTE: There is an EXPEDITED APPEAL PROCESS which is used only when a delay might jeopardize life, health, or the ability to regain maximum functionality OR when requested due to failure to authorize a continuing inpatient hospital stay. A decision is reached within 72 hours on expedited appeals.

See other side for important information